MEDICARE/MEDICAID COORDINATED PLAN
(For Elders and/or Individuals Who are Dually Eligible for Medicare and Medicaid)
BENCHMARK BENEFIT PACKAGE

Section 1 GENERAL OVERVIEW

1.A ADMINISTRATIVE AUTHORITY

42 CFR 431.10

As a condition for receipt of Federal funds under Titles XIX and XXI of the Social Security Act, the Idaho Department of Health and Welfare submits the following Medicare/Medicaid Coordinated Benchmark Benefit Package, and hereby agrees to administer the program in accordance with the provisions of Titles XI, XIX of the Act, and all applicable Federal regulations and other official issuances of the US Department of Health and Human Services.

42 CFR 431.10 1.1
AT-79-29

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Medicare/Medicaid Coordinated Benchmark Benefit Package provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under section 1937 of the Social Security Act. (All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act).

All other provisions of the Medicare/Medicaid Coordinated Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Medicare/Medicaid Coordinated Benchmark Benefit Package describe in this State Plan Amendment shall constitute the State Plan for elders and/or individuals who are dually eligible for Medicare and Medicaid.

1.B POLICY GOALS

The broad policy goal for the provision of the Medicare/Medicaid Coordinated Benchmark Benefit Package for elders and/or individuals who are dually eligible for Medicare and Medicaid is to finance and deliver cost-effective individualized care.

Additional specific goals are:

- To emphasize preventive care and wellness;
- To improve coordination between Medicaid and Medicare coverage;
- To increase nonpublic financing options for long-term care; and
- To ensure participants' dignity and quality of life.

1.C **GEOGRAPHIC CLASSIFICATION**

The Medicare/Medicaid Coordinated Benchmark Benefit Package will be implemented in the geographic locations (counties) listed below. Additional counties will be added as an Medicare Advantage Plan(s) becomes available in the county.

Geographic Area	**Counties**
Southwestern Idaho	Ada, Boise, Canyon, Gem, Owyhee, Payette, Washington
Southeastern Idaho	Bannock, Caribou, Oneida, Power
Northern Idaho	Bonner, Kootenai

1.D SERVICE DELIVERY SYSTEM

Each individual that opts into the Medicare/Medicaid Coordinated Benchmark Benefit Package under the State plan shall select and enroll in a Medicare Advantage Plan.

Att 3.1 C (d)(3)

The policy goals above will be accomplished through the following methods:

- Medicare continues to be the primary payor for dual eligibles (with respect to Medicare covered benefits and, in the case of Medicare Advantage Plans, enhanced benefits included in the Medicare Advantage Plan's Medicare Advantage Plan contract with the Centers for Medicare and Medicaid)
- Utilization of the same provider network in coordinating benefits across Medicare (through Medicare Advantage Plans) and Medicaid.
- Integrated benefits covered by Medicaid will function like a wrap around to those Medicare benefits.

- Services identified in this benchmark plan that are not integrated with the Advantage Plan will still be available through Medicaid providers on a fee for service basis.

Section 2 COVERED POPULATIONS

2.A COVERED INDIVIDUALS

42 CFR 435.10 — 2.2

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available to the groups specified in this Section.

The conditions of eligibility that must be met are specified in the State plan.

Att 2.2- A

The following groups, except those under age 21 or with End Stage Renal Disease (ESRD), will be offered opt-in alternative coverage under the Medicare/Medicaid Coordinated Benchmark Benefit Package if they are eligible for Medicare.

2.A.1 Recipients of Supplemental Security Income

42 CPR 435.120 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals receiving cash assistance as Supplemental Security Income (SSI). This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981, persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

2.A.2 SSI-Related Individuals

1902(a) (10)(A) (i)(II) and 1905 (q) of the Act — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month preceding the first month of eligibility under the requirements of section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619 (a) of the Act and were eligible

for Medicaid; or

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must:

- Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
- Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits;
- Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;
- Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

1634(c) of the Act — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for blind or disabled individuals who are at least 18 years of age and lose SSI eligibility because they become entitled to OASDI child benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

42 CFR 435.122 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who are ineligible for SSI or Optional State Supplements, because of requirements that do not apply under Title XIX of the Act.

42 CFR 435.210, 1902(a)(10)(A)(ii) and 1905(a) of the Act — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals who would be eligible for SSI, or an Optional State Supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

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42 CFR 435.211 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible for AFDC, SSI or an Optional State Supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

42 CFR 435.132 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, these individuals must:

- Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
- Remain institutionalized; and
- Continue to need institutional care.

42 CFR 435.133 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for blind and disabled individuals who:

- Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;
- Were eligible for Medicaid in December 1973 as blind or disabled; and
- For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

42 CFR 435.134 — Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). This also includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

42 CFR 435.135	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Individuals who are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977, and would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.
1634 of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21. and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.
1634(d) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.
1634(e) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

2.A.3 Recipients of Mandatory State Supplements

42 CFR 435.130	Att 2.2-A	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Individuals receiving mandatory state supplements.

2.A.4 Recipients of State Supplementary Payments

42 CFR 435.121, 435.230, 1902(a)(10)(A)(ii)(XI) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act. The following groups of individuals who receive a State supplementary payment under an approved optional State

supplementary payment program that meets the following conditions. The supplement must be based on need and paid in cash on a regular basis and Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. Additionally, the supplement must be available to all individuals in each classification and available on a statewide basis and paid to one or more of the classifications of individuals listed below:

- All aged individuals.
- All blind individuals.
- All disabled individuals.
- Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CPR 435.230.

2.A.5 Recipients of Hospice Care

1902(a)(10)(A)(ii)(VII) of the Act

Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible for Medicaid under this State plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

2.A.6 Recipients of Long-Term Care

Suppl 1 to Att 2.6-A B.4

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for institutionalized individuals and recipients of home and community-based services.

42 CFR 435.231. 1902(a)(10)(A)(ii)(V) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period.
42 CFR435.217	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for groups of individuals who would be eligible for Medicaid under this State plan if they were in a Nursing Facility (NF) or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group(s) covered are listed in the existing 1915(c) waivers. In the event an existing 1915(c) waiver is amended to cover any additional group(s), the Medicare/Medicaid Coordinated Benchmark Benefit Package is available to such group(s) on the effective date of the amendment. Eligibility begins on the first day of the 30-day period. In determining level of care for recipients of long-term care Services**,** the Department provides for an evaluation (and periodic reevaluations) of the need for institutional level of care. Requirements for Level of Care Determinations are specified pursuant to existing waiver programs authorized under section 1915(c) of the Social Security Act.

2.B GENERAL CONDITIONS OF ELIGIBLITY

	Att 2.6-A	Each individual provided the Medicare/Medicaid Coordinated Benchmark Benefit Package must meet the financial conditions of eligibility described in the State plan.
42 CFR Part 435 subpart F	Att 2.6-A	Each individual provided the Medicare/Medicaid Coordinated Benchmark Benefit Package under the State plan must meet the applicable non-financial eligibility conditions.

2.D **APPLICATION PROCEDURES**

42 CFR 435.10 and Subpart J	2.1 2.1(a)	The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance. The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment

in the Medicare/Medicaid Coordinated Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt out of the Medicare/Medicaid Coordinated Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

Section 3 COVERED BENEFITS

3.A GENERAL PROVISIONS

1902(a)(10)(A) and 1905(a) of the Act | Gen Prov 3.1 (a)(1

Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided in the Medicare/Medicaid Coordinated Benchmark Benefit Package as defined in 42 CFR Part 440, Subpart A.

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes benefits that are provided through a Medicare Advantage Plan, benefits that are covered through an integrated Medicaid benefit, and services provided by Medicaid providers. All individuals who are eligible for Medicare may opt in the Medicare/Medicaid Coordinated Plan.

Services not covered by the individuals chosen Medicare Advantage Plan or the Medicaid Integrated Benefit or by Medicaid providers are not covered under this plan.

3.B. HOSPITAL SERVICES

3.B.1 Inpatient Services (Medicare Advantage Plan)

Att 3.1A-PD 1

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Inpatient Hospital Services** permitted under section 1905(a)(1) of the Social Security Act.

3.B.2 Outpatient Services (Medicare Advantage Plan)

42 CFR 440.20 | Att 3.1A-G 2a

the Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) of the Social Security Act.

3.B.3 Emergency Hospital Services (Medicare Advantage Plan)

42 CFR 440.170 Att 3.1A-PD 24e

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Emergency Hospital Services** are provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in the State plan.

3.C AMBULATORY SURGICAL CENTER SERVICES (Medicare Advantage Plan)

42CFR 440.90 Att 3.1A-G 9

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9) of the Social Security Act, including services provided under section 1905(a)(9).

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.D PHYSICIAN SERVICES

3.D.1 Medical Services (Medicare Advantage Plan)

42CFR 440.50 Att 3.1A-G 5a

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Physician Services** permitted under in sections 1905(a)(5) of the Social Security Act. These services included office, clinic, and outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness.

3.D.2 Surgical Services (Medicare Advantage Plan)

Surgical Services. The Medicare/Medicaid Coordinated Benchmark Benefit Package includes professional services rendered by a physician, surgeon or doctor of dental surgery.

3.E OTHER PRACTITIONER SERVICES (Medicare Advantage Plan)

42CFR 440.60 Att 3.1A-G 6

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Other Practitioner Services** specified in sections 1905(a)(6) of the Social Security Act. These services

include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

42CFR 440.166 42CFR 440.165-66	Att 3.1A-G 23 Att 3.1A-PD 23	**Certified Pediatric or Family Nurse Practitioner Services.**
	Att 3.1A-G 6d Att 3.1A-PD 6d	**Physician Assistant Services.**
	Att 3.1A-G 6c Att 3.1A-PD 6c	**Chiropractor Services.**
	Att 3.1A-G 6a Att 3.1A-PD 6a	**Podiatrist Services.**
	Att 3.1A-G 6b Att 3.1A-PD 6b	**Optometrist Services.**
	Att 3.1A-G 17 Gen Prov 3.1 (a)(1)(ii)	**Certified Nurse-Midwife Services**.

3.F PRIMARY CARE CASE MANAGEMENT (Integrated Benefit)

The Medicare/Medicaid Coordinated Benefit Package includes **Primary Care Case Management Services** permitted under in sections 1905(a)(25) of the Social Security Act. These services are provided by a primary care case manager consistent with a waiver program authorized under section 1915(b) of the Social Security Act.

The Medicare Advantage Plan Primary Care Case Management providers will be the same network of PCCM providers under the Basic and Enhanced Plan Benefits Packages. The Medicare Advantage PCCM will be responsible for coordinating Medicare Advantage benefits, Integrated benefits and Medicaid-only provider services.

In addition to primary care case management available pursuant to the 1915(b) waiver program, targeted case management, to the extent it is not available as care coordination through the Medicare Advantage Plan, will be made available to the following target group(s) as permitted in accordance with section 1915(g) of the Act.

Persons with Mental Illness.
Persons receiving Personal Care Services.
Persons with Developmental Disabilities.

3.G PREVENTION SERVICES AND HEALTH ASSISTANCE BENEFIT SERVICES

The Medicare/Medicaid Coordinated Benchmark Benefit

Package includes **Prevention Services** permitted under sections 1905(a)(3), 1905(a)(5), 1905(a)(6), 1905(a)(9), 1905(a)(13), 1905(a)(28) of the Social Security Act.

3.G.1 Adult Physicals (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes an annual preventive health visit. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.G.2 Screening services (Medicare Advantage Plan)

Att 3.1A-PD13b

Mammography Services. The Medicare/Medicaid Coordinated Benchmark Benefit Package includes screening Mammographies. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.G.3 Prevention and Health Assistance (PHA) Benefits (Integrated Benefit)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes health/wellness education and intervention services as defined by the individual Medicare Advantage Plan.

Enhanced PHA benefits made available under the Medicare/Medicaid Coordinated Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- Are obese.
- Are diabetic

3.H LABORATORY AND RADIOLOGICAL SERVICES (Medicare Advantage Plan)

42 CFR 440.30 Att 3.1A-G 3

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

3.I PRESCRIBED DRUGS

3.I PRESCRIBED DRUGS UNDER PART D (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Prescribed Drugs** permitted under sections

1905(a)(12) of the Social Security Act. These services include drugs covered under the individual Medicare Advantage Plan subject to the Medicare Advantage Plan limitations and Medicare Part D excluded Drugs.

3.2 MEDICARE EXCLUDED DRUGS (Integrated Benefit)

Under this plan, the Medicare Advantage Plan becomes responsible for the Medicare excluded drugs and is expected to provide this coverage through the same network of providers as the Medicare Part D drugs.

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes the following Medicare excluded or otherwise restricted drugs or classes of drugs.

Lipase inhibitors subject to Prior Authorization.

Prescription Cough & Cold symptomatic relief.

Therapeutic Vitamins which may include:

- Injectable Vitamin B12;
- Vitamin K and analogues;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Nonlegend Products which may include:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts;
- Permethrin; and
- OTC products as authorized by applicable Department rules.

Barbiturates.

Benezodiazepines.

Att 3.1A-PD 12A3

Additional Covered Drug Products. Additional drug products will be covered as follows:

Att 3.1A-PD 12A3(a)

- Therapeutic Vitamins;

Att 3.1A-PD 12A3(a)(i)

- Injectable Vitamin B12 (cyanocobalamin and analogues);

Att 3.1A-PD 12A3(a)(ii)

- Vitamin K and analogues;

Att 3.1A-PD 12A3(a)(iii)

- Pediatric vitamin-fluoride preparations;

Att 3.1A-PD 12A3(a)(iv)
- Legend prenatal vitamins for pregnant or lactating women;

Att 3.1A-PD 12A3(a)(v)
- Legend folic acid;

Att 3.1A-PD 12A3(a)(vi)
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and

Att 3.1A-PD 12A3(a)(vii)
- Legend Vitamin D and analogues.

Att 3.1A-PD 12A3(b)
Prescriptions for non-legend products will be covered as follows:

Att 3.1A-PD 12A3(b)(i)
- Insulin;

Att 3.1A-PD 12A3(b)(ii)
- Disposable insulin syringes and needles;

Att 3.1A-PD 12A3(b)(iii)
- Oral iron salts; and

Att 3.1A-PD 12A3(b)(iv)
- Permethrin.

- Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

3.J FAMILY PLANNING SERVICES (Medicare Advantage Plan)

42 CFR 441.20, AT-78-90 — Gen Prov 3.1(e)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) of the Social Security Act.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services (Medicare Advantage Plan)

42 CFR 441.101, 42 CFR 431.620(c) and (d) AT-79-29 — Gen Prov 3.3

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Medicare/Medicaid Coordinated Benchmark Benefit Package includes **inpatient psychiatric services for individuals in Institutions for Mental Diseases** permitted under section 1905(a)(14) of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.K.2 Outpatient Mental Health Services (Medicare Advantage Plan)

42CFR 440.90 — Att 3.1A-G 9

In addition to Mental Health Services covered under Outpatient Hospital Services, the Medicare/Medicaid Coordinated

Benchmark Benefit Package includes **Clinic Services** permitted under sections 1905(a)(9), 1905(a)(13) of the Social Security Act.

Att 3.1A-PD 9
Att 3.1A-PD 9a

Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.K.3 Psychosocial Rehabilitative Services (PSR) (Medicaid Providers)

Att 3.1A-PD
13d(2)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Psychosocial Rehabilitation (PSR) services** provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community. These services are outlined in applicable Department rules.

Att 3.1A-PD
13d(2)(a)

Limitations. The following service limitations apply to The Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department are:

Att 3.1A-PD
13d(2)(a)(i)

- A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours in a calendar year.

Att 3.1A-PD
13d(2)(a)(ii)

- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.

Att 3.1A-PD
13d(2)(a)(iii)

- Community crisis support services are limited to a maximum of five (5) consecutive days and must receive prior authorization from the Division of Family and Community Services.

Att 3.1A-PD
13d(2)(a)(iv)

- Individual and group psychosocial rehabilitation services are limited to twenty hours (20) per week and must receive prior authorization from the Division of Family and Community Services. Services in excess of twenty (20) hours require additional review and prior authorization by the Department.

Excluded services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Treatment services rendered to recipients residing in inpatient

medical facilities including nursing facilities or hospitals, is excluded.

Recreational therapy, which includes activities which are primarily social or recreational in nature, is excluded.

Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job coaching, is excluded.

Staff performance of household tasks and chores, is excluded.

Client staffing within the same PSR agency, is excluded.

Services for the treatment of other individuals, such as family members, is excluded.

Any other services not listed in applicable Department rules, are excluded.

3.L HOME HEALTH CARE (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.M THERAPY SERVICES (Medicare Advantage Plan)

Att 3.1A-G 7d

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Therapy Services** permitted under sections 1905(a)(11), 1905(a)(13) of the Social Security Act. These services include physical therapy, occupational therapy, or speech pathology and Audiology services.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.N SPEECH, HEARING AND LANGUAGE SERVICES (Medicare Advantage Plan)

Att 3.1A-G 11c

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Speech, Hearing and Language Services** permitted under section 1905(a)(6) of the Social Security Act. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.O MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.O.1 Medical Equipment and Supplies (Medicare Advantage Plan)

Att 3.1A-G 7c

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under section 1905(a)(28) of the Social Security Act. These services include durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.O.2 Specialized Medical Equipment and Supplies (Integrated Benefit)

The Enhanced Benchmark Benefit Package includes **Specialized Medical Equipment and Supplies** permitted under sections 1905(a)(4)(B) or 1915(c)(4)(B) of the Social Security Act.

Specialized Medical Equipment and Supplies are covered for participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.O.3 Prosthetic Devices (Medicare Advantage Plan)

42CFR 440.120 Att 3.1A-G 12

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(6), 1905(a)(12) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.P VISION SERVICES (Medicare Advantage Plan)

42CFR 440.120 Att 3.1A-G 12

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(12) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes Medical and Surgical Services furnished by a dentist permitted under sections 1905(a)(5)(B), 1905(a)(6) of the Social Security Act. (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the limitations of practice imposed by state law.

3.Q.2 Other Dental Care (Integrated Benefit)

The Enhanced Benchmark Benefit Package includes **Other Dental Care** permitted under sections 1905(a)(5)(B), 1905(a)(6) of the Social Security Act. These services include professional dental services provided by a licensed dentist or denturist as described in applicable Department rules.

3.R ESSENTIAL PROVIDERS

42CFR 33440.90 — Att 3.1A-G 9

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Clinic Services and Rehabilitative Services** furnished by certain essential providers permitted under sections 1905(a)(9), 1905(a)(13) of the Social Security Act.

Att 3.1A-PD 9

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services (Medicaid Providers)

42CFR 440.20 — Att 3.1A-G 2b

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services (Medicaid Providers)

Att 3.1A-G 2c

Federally Qualified Health Center (FQHC) services and other

ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Att 3.1A-PD 2c

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services (Medicaid Providers)

42 CFR 431.110(b) AT-78-90

Gen Prov 3.1(g) Gen Prov 3.1(g)

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3.S MEDICAL TRANSPORTATION SERVICES (Medicaid Providers)

42 CFR 431.53

Gen Prov 3.1 (c)(1)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Medical Transportation Services** permitted under sections 1905(a)(26), 1905(a)(6) of the Social Security Act.

42CFR 440.170

Att 3.1A-PD 24a

These services include transportation services and assistance for eligible persons to medical facilities in the form of necessary transportation is provided.

Necessary transportation includes transportation for full benefit dual eligible individuals to acquire their Medicare Part D prescription medications.

Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

The Department operates a Brokered Transportation system. The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon the request of CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

The Department will operate the broker system without regard to the statewideness requirements of section 1902(a)(1) of the Social Security Act. The broker system is operated only in Region 5, Region 6, and Region 7.

The Department will operate the broker system without regard

to the freedom of choice requirements of section 1902(a)(23) of the Social Security Act. Recipients are required to use transportation providers with established agreements under the broker system.

Transportation services under the broker system will include:

- Wheelchair van;
- Taxi;
- Stretcher care;
- Bus passes;
- Tickets;
- Secured transportation; and
- Such other non-emergency transportation covered under the State Plan.

Att 3.1D C

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Medicare/Medicaid Coordinated Benchmark Benefit Package are excluded.

3.T LONG-TERM CARE SERVICES

3.T.1 Nursing Facility Services (Medicaid Providers)

Att 3.1A-G 4a

42CFR 440.40

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in

		accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
42 CFR 483.10	Gen Prov 3.1 (c)(2)	The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).
		Limitations. The following service limitations apply to Medical Assistance covered under this State plan.
	Att 3.1A-PD 4a	Skilled nursing facility services must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment.
42 CFR 440.140	Att 3.1A-PD 24d	Nursing facility care services must have prior authorization before payment is made.

3.T.2 Personal Care Services (Medicaid Providers)

	Att 3.1A-G 24f	The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Personal Care Services** permitted under section 1905(a)(24) of the Social Security Act. These services include care provided in recipient's home**,** prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
	Att 3.1A-PD 24f	Personal Care Services are provided when ordered by a physician, supervised by a registered nurse, and approved by the Department. R.N. supervision must occur at least every ninety (90) days. Clients whose provider is expected to carryout training programs in the recipient's home for developmentally disabled individuals will also have supervision at least every ninety (90) days by a Qualified Mental Retardation Professional.
	Att 3.1A-PD 26	Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: • authorized for the individual by a physician in accordance with a plan of treatment; • provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and • furnished in a home.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Services are limited to sixteen (16) hours per calendar week, per eligible client.

Att 3.1A-PD
4b(xvii)(g)

3.T.3 Home and Community-Based Services (Medicaid Providers)

Other Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.U HOSPICE CARE (Medicare Advantage Plan)

Att 3.1A-G 18

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Hospice Care** permitted under sections 1905(a)(18) and 1905(o) of the Act. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.V DEVELOPMENTAL DISABILITY SERVICES

3.V.1 Intermediate Care Facility Services (ICF/MR) (Medicaid Providers)

42CFR 440.150 Att 3.1A-G 15a

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Intermediate Care Facility Services** permitted under section 1905(a)(15) of the Social Security Act. Services in an Intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) are for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Att 3.1A-PD 15a

Intermediate care services including such services in a public institution for the mentally retarded or persons with related conditions must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to eligibility for intermediate care services and authorization of payment.

Att 3.1A-G 15b

Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

3.V.2 Developmental Disability Agency Services (Medicaid Providers)

Att 3.1A-PD 13d
Att 3.1A-PD 13d(1)(a)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Community-Based Services** permitted under section 1905(a)(13) of the Social Security Act. These services include Rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are that licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Att 3.1A-PD 4b(xvii)(d)

Rehabilitative services provided by Developmental Disabilities Agencies are limited to twelve (12) hours reimbursable time allowed for the combination of all evaluations or diagnostic services; the limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy.

3.V.3 Other Home and Community-Based Services (Medicaid Providers)

Other Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.W MEDICARE ADVANTAGE COST SHARING

The Department pays cost sharing, for which a full benefit dual eligible individual would be liable, for enrollment in a participating Medicare Advantage Plan.